



Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program
Review of the
VA Medical Center
Louisville, Kentucky

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Office of Inspector General Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities and regional offices on a cyclical basis. The purpose of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and agency policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Conduct fraud and integrity awareness briefings for facility staff.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, members of Congress, or others.

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Combined Assessment Program Review VA Medical Center Louisville, Kentucky

Executive Summary

Introduction. During the week of February 26 – March 2, 2001, the VA Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of VA Medical Center (VAMC) Louisville, Kentucky. The purpose of the review was to evaluate selected VAMC operations, focusing on patient care administration, quality management, and financial and administrative controls. During the review we also provided fraud and integrity awareness training to about 115 VAMC employees.

Results of Review. VAMC managers actively supported quality patient care and performance improvement. The quality management program was comprehensive and provided oversight of the quality of care. In addition, financial and administrative activities were generally operating satisfactorily, and management controls were generally effective.

We made recommendations for improvements in the following areas:

- Accountability and security for controlled substances.
- Contract community nursing home (CCNH) inspection procedures.
- Aspects of the Home Healthcare Program.
- Trending and analyzing infection control and risk management data.
- Monitoring resident physician progress and supervision.
- Timekeeping for and attendance by part-time physicians.
- Collection of accounts receivable.
- Implementation of the Decision Support System (DSS).
- Medical care billing compliance internal controls.
- Security for the Agent Cashier.
- Background investigations for those with “sensitive” information technology access.

We also made suggestions in areas that need improvement, but did not merit formal recommendations:

- Documentation of primary care for mental health patients.
- Inclusion of treatment plans for mental health care in medical records.
- Documentation of informed consents for medical research in patient medical records.
- Documentation of informed consents for surgery in patient medical records.
- Pain management policy and practice.
- Certain environment of care issues.
- Timeliness of approval of Government purchase card transactions.
- Identification of all costs in enhanced use sharing agreements.
- Execution and proper documentation of the means test.

- Adequacy of the report of survey process.
- Utilization of a sports and fitness clinic.
- Concerns of employees and patients.

Medical Center Director's Comments. The Director agreed with our recommendations and suggestions and provided acceptable implementation plans, with the exception of the issue concerning resident supervision. In this case, the OIG and the Medical Center Director will jointly request a site review by staff in the Veterans Health Administration (VHA) Office of the Chief Academic Affiliations Officer to determine the specific steps that the VAMC needs to take to be in full compliance with VHA requirements for resident supervision. We consider all other issues resolved but may follow up on implementation actions.

(original signed by:)
RICHARD J. GRIFFIN
Inspector General

Introduction

VAMC Louisville provides tertiary medical, surgical, and psychiatric care. Outpatient care is provided at the main facility and at four community-based outpatient clinics (CBOCs) located in Louisville, Fort Knox, and Shively, Kentucky and in New Albany, Indiana. The VAMC is part of Veterans Integrated Service Network (VISN) 9 and serves a population of about 156,000 veterans in a primary service area that includes 23 counties in central and western Kentucky and 12 counties in southern Indiana.

Programs. The VAMC has 110 operating beds (59 medical, 28 psychiatric, and 23 surgical) and offers acute, specialized, and intermediate care services. The medical center also provides support to a veterans outreach center, a Veterans Benefits Administration (VBA) regional office, and four national cemeteries.

Affiliations. The VAMC has a primary affiliation with the University of Louisville School of Medicine, with active residency programs in all major medical specialties and subspecialties, in addition to a residency in primary care. The VAMC is also affiliated with 28 other institutions providing training in such areas as nursing, audiology and speech pathology, dentistry, nuclear medicine, and rehabilitative medicine. In Fiscal Year (FY) 2000, Research and Development Service had 39 principal investigators with 122 active projects, of which 18 projects were funded by VA.

Resources. FY 2000 medical care expenditures totaled \$104.8 million. The FY 2001 budget was about \$109 million, including projected revenue from Medical Care Collection Fund (MCCF) activities. Budgeted FY 2001 staffing was 1,055 full-time equivalent employees (FTEE).

Workload. In FY 2000, the VAMC treated 34,898 unique patients, a 2.5 percent increase from FY 1999. The average daily inpatient census in FY 2000 was 83 patients, and outpatient care workload totaled 248,434 visits.

Objectives and Scope of CAP Review

The purposes of the CAP review were to evaluate selected clinical, financial, and administrative operations and to provide fraud and integrity awareness training to VAMC employees.

Objectives. We reviewed selected clinical activities to evaluate the effectiveness of patient care administration and quality management. Patient care administration is the process of planning and delivering patient care. Quality management is the process of monitoring the quality of patient care to identify, evaluate, and correct noncompliant or inappropriate practices and conditions.

We also reviewed selected financial and administrative activities to evaluate the effectiveness of management controls. These controls are the policies, procedures, and information systems used

to safeguard assets, prevent and detect errors and fraud, and ensure that organizational goals and objectives are met.

Scope. In performing the review, we inspected work areas; interviewed managers, employees and patients; and reviewed clinical, financial, and administrative records. We also surveyed employees and patients about quality of care, timeliness of service, and satisfaction with care provided. The full survey results were shared with VAMC management. The review covered the following 28 clinical and administrative activities and management controls:

Accounts Receivable	Inventory Management
Agent Cashier	Means Testing
Contract Community Nursing Homes	Medical Care Billing Compliance
Contracting	Medical Care Collection Fund
Credentialing and Privileging	Mental Health Primary Care
Decision Support System	Pain Management
Drug Accountability	Procurement of Printing Services
Employee Education	Psychiatry Service
Enhanced Use Sharing Agreements	Research Consent
Environment of Care	Resident Supervision
Equipment Accountability	Surgical Consent
Government Purchase Card Program	Timekeeping for Part-Time Physicians
Home Healthcare Program	Unliquidated Obligations
Information Technology Security	Utilization of a Sports and Fitness Clinic

We also presented five fraud and integrity awareness briefings for VAMC employees. About 115 employees attended these briefings, which covered procedures for reporting suspected criminal activity to the OIG, and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

The review was performed in accordance with the OIG standard operating procedures for CAP reviews and covered VAMC operations for FYs 1999, 2000, and 2001 (through February 2001).

Results of Review

Clinical and Management Controls Were Generally Satisfactory

VAMC managers had created an environment that supported quality patient care and performance improvement. The quality management program effectively monitored the quality of patient care using national and local performance measures, patient safety management, and utilization review. The financial and administrative activities reviewed were generally operating satisfactorily, and management controls were generally effective. As illustrated by the following examples, we found indicators of positive management actions in many of the activities reviewed.

Management demonstrated a commitment to veterans and employees. Managers made daily rounds throughout the facility and actively sought ways of improving patient satisfaction. Top managers met twice yearly with Congressional and Veterans Service Organization representatives to receive feedback about facility services. Managers expressed a desire for the VAMC to be an employer of choice in the Louisville area. Recognition ceremonies were held periodically to publicly demonstrate management's appreciation for employee contributions to improving services provided to veterans.

Performance improvement monitors had been initiated and quality management activities were evident. The VAMC had a comprehensive quality management and performance improvement program designed to oversee patient care activities, including risk management and infection control. Ongoing quality of care monitors included restraint use, adverse drug events, falls, and hospital acquired infection rates. The facility's committee structure encouraged and facilitated the flow of quality management and performance improvement information. VAMC employees were involved in improving efficiency of processes and the quality of patient care. Process action teams were actively used to address issues affecting the entire facility.

Employee education documentation was recorded timely and consistently. VAMC staff had centralized employee education records in the Training and Education Management Program system. Education staff documented employee training in the system within 48 hours of receipt of notifications of training. Training reports were provided to service managers monthly and as needed.

An enhanced use sharing agreement with the Army improved efficiency. VAMC staff negotiated an enhanced use sharing agreement with the Army to provide medical services to military personnel and dependents. This agreement allowed VAMC staff to provide CBOC care to veterans at Fort Knox with no cost to VA for the facility in which the care was provided.

Procurement of printing services adhered to criteria. Printing practices adhered to Government Printing Office (GPO) criteria regulating the amount that could be spent on publications and other printing projects. When appropriate, printing projects beyond local capabilities were referred to GPO as required.

Management had implemented a successful inventory management program. The Generic Inventory Package had been implemented as required by VHA policy. An inventory of selected items in the main warehouse and Supply Processing and Distribution section revealed no significant discrepancies.

Contracting procedures were adequate. Our review of seven contracts totaling approximately \$3 million found that VAMC contracting staff had adhered to required cost and pricing procedures, solicitations for bids, and approval processes.

Physician credentialing and privileging was effective. VAMC staff had developed effective controls to ensure that documentation of credentialing and privileging information for staff physicians was maintained.

Opportunities for Improving Clinical and Management Controls

Accountability and security for controlled substances needed improvement. Reported inventory balances of controlled substances in the VAMC Pharmacy could not be verified, and monthly narcotics inspection procedures needed improvement. Significant inventory discrepancies were not reported to law enforcement and oversight organizations. Outdated controlled substances were not destroyed quarterly. In addition, physical security of the Outpatient Pharmacy was not adequate. Although VA policy clearly outlines procedures for all of the above functions, VAMC staff were not following those procedures.

Controlled substances were not accounted for. We reviewed reports of monthly, unannounced narcotics inspections for a 12-month period, and we requested and observed an unannounced inspection. We found that:

- There were significant discrepancies between the results of controlled substances inventories and recorded balances.
- Discrepancies reported by facility inspectors were not routinely resolved.
- Accountability documents were routinely and inappropriately “adjusted.”

During the narcotics inspection that we observed on February 27, 2001, inspectors identified discrepancies between accountability records and physical counts for 17 controlled substances. Counts of nine items were higher than reported balances, and counts of eight items were below reported balances. Two of these 17 discrepancies were resolved, 3 remained unresolved pending further review, and Pharmacy staff improperly “adjusted” 12 records to make accountability records agree with the physical counts found during the inspection. These adjustments were made with no further review. Pharmacy staff made these adjustments even though the discrepancies indicated serious accountability problems. For example, one discrepancy involved a shortage of 1,040 tablets of propoxyphene and another involved a shortage of 1,000 tablets of codeine. Both shortages occurred in the main Pharmacy vault. Pharmacy staff stated that making such adjustments was a common local practice.

Reports of earlier monthly inspections confirmed that such adjustments were routine. For example, during a February 15, 2001, inspection, inspectors identified discrepancies for 21 controlled substances. Pharmacy staff adjusted accountability documents for 16 of these without attempting to resolve the discrepancies. During this inspection, there were 1,000 tablets of oxycodone, 1,000 tablets of diazepam, and 400 tablets of hydrocodone that should have been on hand according to accountability documents, but were not.

For both of these inspections (February 15 and 27, 2001) inspectors noted on inspection documents that the discrepancies were “resolved” because the drugs in question had been transferred from the Outpatient Pharmacy vault to an automated dispensing system (which had been in place for about 18 months at the time of our review). However, because the dispensing system did not inventory drugs processed through it, there were no reliable records confirming the receipt of drugs into the system. According to narcotics inspectors, they did not follow up on these discrepancies because they had been told that discrepancies within the Pharmacy were a matter between Pharmacy Service and the Director’s Office. In contrast, when inspectors found discrepancies in patient care areas they complied with VHA policies in accounting for and resolving the discrepancies.

The Chief, Pharmacy Service told us that difficulties with the automated dispensing system probably caused the apparent shortages. Pharmacy staff also stated that, while they had tried to account for controlled substances removed from the Pharmacy vault for dispensing through the automated system, these efforts had been sporadic and, for the most part, unsuccessful.

This accountability problem with the dispensing system was noted as early as June 2000 when an inspector identified a shortage of 1,998 Tylenol[®] with codeine tablets. The inspector recommended developing controls for the automated dispensing system, but Pharmacy staff never acted on the recommendation, and that shortage, like others since, was never resolved.

Monthly narcotics inspections needed improvement. The manner in which narcotics inspections were conducted may have contributed to overall accountability problems for narcotics.

- Inspectors did not inspect all narcotics storage areas simultaneously, and inspections took up to 3 weeks to complete. Accordingly, controlled substances could be moved from areas already inspected to areas awaiting inspection, allowing the undetected diversion of drugs. In contrast, the inspection we requested and observed took only 5 hours to complete for the entire VAMC.
- Inspectors did not inventory drugs awaiting disposal, as required by VHA policy. This also left these drugs vulnerable to diversion. Inspectors stated that they were unaware of this requirement.

Discrepancies were not reported to law enforcement and oversight organizations. VHA policy requires that management notify facility police, the VA OIG, and the Drug Enforcement Administration (DEA) in cases of recurring shortages, loss of more than several doses, or when there is indication of theft. However, none of the shortages noted above had been reported until our visit. The Chief, Pharmacy Service incorrectly believed that VA and DEA authorities did not need to be notified of losses smaller than 10,000 units. Because the narcotics inventory

discrepancies noted above involved significant quantities of drugs and in some cases were recurring, they should have been reported to both OIG and DEA, as well as to facility police.

Controlled substances were not destroyed quarterly as required. Two weeks before our visit in February 2001, 179 outdated controlled drugs were destroyed. However, the most recent destruction before that was 8 months earlier, in June 2000, not every 3 months as required.

Physical security was inadequate. A window opening through which Pharmacy staff passed pharmaceuticals to patients in the main outpatient Pharmacy waiting area did not meet VHA security requirements. During business hours, the opening provided an accessible, people-friendly appearance, and it was secured during off-hours by a pull-down grate. However, the wall beneath the grate could easily be kicked in or otherwise compromised, and the grate itself did not comply with VHA security standards since the area just inside the window contained controlled substances. The grate should be replaced with a bulletproof dispensing window, and the wall beneath it should be reinforced to prevent forced entry.

Management action was immediate. While we were onsite, VAMC management initiated actions to correct most of the issues discussed above. As part of this effort, they requested assistance from our Office of Investigations¹, DEA, and VISN 9 to establish accurate inventory balances as a starting point for an improved system of accountability. Pharmacy staff planned to conduct a wall-to-wall inventory of the main Pharmacy dispensing areas. In addition, management stated that procedural problems would be addressed, and that VHA and DEA policies governing the reporting of discrepancies would be adhered to in the future.

Recommendation 1. The Medical Center Director should ensure that:

- a. Accurate inventory balances are established.
- b. All controlled substances are accounted for after each narcotics inspection and discrepancies are properly resolved.
- c. Arbitrary changes are not made to VAMC controlled substances accountability records, and the only adjustments that are made are justified by legitimate reasons.
- d. Monthly narcotics inventories are conducted in accordance with VHA policies.
- e. Reportable discrepancies involving controlled substances are reported to appropriate authorities.
- f. Expired controlled substances are disposed of quarterly.
- g. Security problems in the Outpatient Pharmacy waiting area are corrected.

Medical Center Director Comments

In response to the recommendations provided in this review: an accurate inventory of all controlled substances has been established; all controlled substances have been accounted for after each narcotics inspection and/or discrepancies have been properly resolved; all changes to

¹ OIG Special Agents explained VHA, state, and Federal criteria applicable to the handling of controlled substances.

controlled substances records are documented and justified; reportable discrepancies involving controlled substances are communicated to OIG, DEA and facility police; narcotics inspections policy and procedures are being reviewed and revised; and expired/returned-for-credit controlled substances are returned or destroyed quarterly.

Specifically, the following actions have been taken:

1. As recommended, we have changed our process to require that Pharmacy staff count the contents of all containers as they are opened in the Pharmacy vault. We have verified that there are discrepancies in counts made by the manufacturers. Many of the discrepancies noted in the investigation could be attributed to these manufacturer errors. However, we have made every effort, including the purchase of an automated counter for use in the vault, to verify the contents of each bottle of controlled substances as it is opened in the vault prior to being used in dispensing.
2. Following the OIG inspection, a new process was developed and implemented involving the transfer of all controlled substances from the Pharmacy vault to the Optifil II (an automated Pharmacy system). All such transfers are documented in the Veterans Information Systems Technology Architecture (VISTA) system before the drugs are moved to the Optifil II. In addition, the Optifil II technicians inventory drugs taken to the Optifil II before they are loaded into the Optifil II. Any discrepancies in the transferred quantities due to manufacturers' errors in packaging or any other reason are noted and investigated at this time and recorded and corrected in the inventory. A new automated counter was purchased and placed in the locked controlled substances area of the Optifil II for this purpose.
3. In addition, a third counter was purchased and placed in the dispensing area of the Pharmacy to perform a final verification count on all prescriptions filled through the Optifil II. Each controlled substance prescription is counted at least twice by automated equipment in addition to the count performed as the drug is loaded into the Optifil II. Pharmacy personnel have tracked the accuracy of the automated equipment, and we have removed controlled substances from the Optifil II if the cells could not be made to count with near 100 percent accuracy all the time. Those drugs have been returned to the vault and are hand counted by Pharmacy personnel assigned to the vault.
4. Because those cells remaining in the Optifil II count the drugs in the cells so accurately, we have now changed (August 2001) our procedure, and we will spot check the counts from the cells several times a day instead of counting the contents of every controlled substance prescription. Counting everything does impact our waiting time and places additional stress on our staff. Since accuracy is so high, we believe that this is an acceptable procedure for assuring accuracy of dispensing actions and accountability of controlled substances. Controlled substances removed from the vault and transferred to the Optifil II inventory will continue to be counted with each transaction.
5. Pharmacy Service has implemented a notification system for any missing controlled substances when the loss cannot be resolved at the local level. OIG inspectors, the local DEA office and facility police are notified by facsimile of each unresolved loss of a controlled

substance. Most occurrences since the beginning of this process have involved patient-reported losses of medications shipped either from the Consolidated Mail Outpatient Pharmacy or of medications mailed from the medical center.

6. As stated in the report, controlled substances were not destroyed for approximately eight months before the OIG inspection in February 2001, at which time a large quantity of expired controlled substances was destroyed. The Pharmacy will comply with the policy of destroying returned/expired controlled substances quarterly. VA has a national contract with Guaranteed Returns of East Setauket, New York, and arrangements are made quarterly to destroy/return any controlled substances on hand. Expired/returned-for-credit controlled substances are now inventoried during the monthly controlled substance inventory by a disinterested third party inspector.

7. Narcotics inspection policies and procedures are still being revised. However, PYXIS units are being installed on all inpatient units. These pharmaceutical-dispensing units will assist in maintaining accurate ward narcotics inventories and will ease the process of narcotics inspections.

8. Pharmacy Service supports the open Pharmacy concept in our patient counseling area. We have removed all narcotics from the patient counseling area in response to the OIG recommendations. We continue to assess methods of providing additional security for the area that will also permit us to maintain a patient-friendly area. We will continue to assess these security concerns until a satisfactory resolution has been attained.

Office of Inspector General Comments

The Medical Center Director's comments and implementation actions are acceptable. We consider these issues resolved but may follow up on implementation actions.

CCNH inspections needed improvement. VHA policy requires that VAMC Directors send out teams to inspect CCNHs. These inspections should be performed at least annually and at least 60 days prior to renewing an existing contract. Reviews of documentation for five nursing home contracts revealed that VAMC staff did not always follow up on inspection findings to determine if deficiencies were corrected, nor did they perform inspections annually as required. For example:

- VA inspectors had cited fire and safety deficiencies at four facilities, but corrective actions were not documented. To illustrate, VAMC staff received no plan for corrective action from one facility and did not verify planned or claimed corrective actions from the other three.
- VAMC inspectors cited a nursing care deficiency at one facility but did not follow up to obtain a plan for corrective action.
- Inspectors cited one CCNH for a "social and quality of life deficiency." There was no documentation that the CCNH responded or that VAMC staff followed up.
- VAMC staff renewed one CCNH contract without performing an inspection.

VAMC management needs to ensure that all requirements for CCNHs are met.

Recommendation 2. The Medical Center Director should ensure that:

- a. Deficiencies cited as a result of CCNH inspections are corrected.
- b. Inspections of CCNHs occur timely before contracts are renewed.

Medical Center Director Comments

The folders of the CCNHs reviewed by OIG staff included deficiencies identified by the social worker, nurse, and/or fire safety officer on VA's inspection team. The deficiencies have been communicated in writing to the nursing home administrators, and the nursing home administrators have responded in writing with plans of corrective actions. The VA social worker (who visits each CCNH at least once each 30 days) and/or the VA nurse (who visits each CCNH at least once each 60 days) will document correction of deficiencies identified in the last VA inspections during their next scheduled visits. Copies of this documentation will be placed in the CCNH inspection folders in the Social Work office and copies will be sent to the VISN 9 Acquisition Service Center in Murfreesboro, as that center issues contracts for homes that do not participate in the Regional Contract Nursing Home program. If the deficiencies have not been corrected by the time of the inspections, placement of VA patients will be suspended until the CCNHs correct the identified deficiencies.

Based on guidance from VHA's Office of Geriatrics and Extended Care (G&EC), VAMC Louisville will use the Health Care Financing Administration's OSCAR system² for evaluation of CCNHs. G&EC makes this recommendation with some confidence. The 1,300 nursing homes in the national Multi-State Contract (MSC) program were reviewed using OSCAR as the sole selection instrument. The Health Systems Research and Development evaluation of the MSC initiative found MSC homes of slightly better quality than those under local contracts. If the OSCAR process identifies deficiencies at a specific nursing home, a special purpose visit by the nurse, social worker, and fire safety officer will be scheduled prior to contract renewal.

Office of Inspector General Comments

The Medical Center Director's comments and implementation actions are acceptable. We consider these issues resolved but may follow up on implementation actions.

A review of the Home Healthcare Program was warranted. Five conditions relating to the VAMC's Home Healthcare Program needed to be corrected.

- A complainant alleged a conflict of interest involving the VAMC's Home Healthcare Program Coordinator. The Coordinator served on the advisory board of a local home healthcare agency and the complainant alleged that, after the Coordinator's appointment to

² OSCAR (for Online Survey Certification and Reporting) is HCFA's database of nursing facility residents' census information, which is collected by state surveyors on an annual basis. This information is generally used to pinpoint areas of concern over nursing facilities' patient care, and ensure these facilities' compliance with HCFA's prescribed health care practice regulations.

that board, there was a significant increase in VAMC referrals to that agency. The Coordinator was indeed serving on the agency's board, and she received compensation of \$200 per board meeting once or twice per year. However, in reviewing patterns of referrals and expenditures to home healthcare agencies during FYs 1999, 2000, and 2001 (through January), we found nothing to indicate that the agency in question or any other agency was assigned a disproportionate share of the VAMC's home healthcare workload. Neither had there been a significant increase in referrals to the agency. We referred this matter to the VA Regional Counsel for an opinion on the possible conflict of interest, and the Regional Counsel recommended that the coordinator resign from the advisory board. The Coordinator immediately resigned from the board.

- The VAMC did not have written procedures for referring patients to home healthcare agencies. Although nurses and clerical staff were able to explain factors that they considered in making home healthcare referrals, there were no written local or VHA guidelines concerning how to select the appropriate home healthcare agency.
- VAMC records did not contain documentation to verify that services provided and billed by home healthcare agencies were actually delivered. Nursing staff responsible for home healthcare referrals did not routinely review home healthcare agencies' notes to determine if services requested by clinicians were provided. In addition, Fee Services staff did not verify that the visits authorized for payment were actually made by the home healthcare agency.
- VAMC staff did not obtain performance improvement data from home healthcare agencies. Performance improvement data was not reviewed to evaluate care provided to veteran patients.
- Patient medical records did not document home healthcare visits. VAMC staff responsible for filing and storage of medical records told us that documentation of home healthcare visits was voluminous and that there were not enough employees to file homecare visit documentation in patient records. This data should be filed in each patient's medical record because it documents part of the overall continuum of care of the patient. Therefore, it should be available to every medical care practitioner who accesses patient records.

Recommendation 3. The Medical Center Director should ensure that:

- a. Home healthcare referral policies are developed.
- b. Home healthcare visits authorized for payment are actually provided.
- c. VAMC staff obtain and review performance improvement data from home healthcare agencies.
- d. Documentation of home healthcare visits is contained in patients' medical records.

Medical Center Director Comments

The Chief Nurse has recommended that the Administrative Executive Board and/or the Clinical Executive Board (CEB) review and make recommendations concerning staff appointments to

community, state and national boards, following regulatory review by General Counsel. An operating procedure entitled “Agency Selection” has been developed and implemented which delineates specific guidelines for agency selection. It is our policy that progress notes or other documentation of home health visits, signed by the patient indicating the provider’s presence in the home, are to be submitted by the home healthcare agency with their monthly invoices. We continue to seek means of improving this process further to discourage falsified reports. This documentation is reviewed against the authorization and used as a basis for certifying all invoices prior to payment. It has been our practice that this documentation is forwarded to Community Health for review to ensure compliance with treatment plans. Staff involved in this process have been reminded and reeducated concerning these requirements. Home healthcare agencies are required to submit performance improvement measures to Community Health. This data is reviewed by the Community Health Coordinator upon receipt, and any negative findings are discussed for resolution. In addition, the Community Health staff, on a case-by-case basis, review individual patient outcomes and consult with the home healthcare agency when outcomes are not as expected. The individual agency is held accountable for those outcomes. If care is not improved, referrals are no longer made to that agency. Progress notes are entered into the Computerized Patient Record System (CPRS) for patients receiving home healthcare and is, therefore, available upon demand to any practitioner involved in the care of the patient. This is a laborious process due to the volume of the documentation that is received from home healthcare agencies on a daily basis. This will be simplified in the near future when scanning equipment becomes available. At that time, all documents received from the agencies will be scanned into the electronic medical record for immediate availability.

Office of Inspector General Comments

The Medical Center Director’s comments and implementation actions are acceptable. We consider these issues resolved but may follow up on implementation actions.

Infection control (IC) and risk management data needed to be reported in a different form and trended. IC and risk management issues were reported to appropriate VAMC committees, but the data could not be easily trended or analyzed. For example, IC data was collected monthly and reported to the IC Committee in narrative form. This form of reporting did not allow committee staff to easily identify trends that might require corrective actions. This was a vulnerability identified in the facility’s 1998 Joint Commission on Accreditation of Healthcare Organizations survey, but was not corrected.

In addition, risk management reports on patient falls and episodes of restraint were not trended by unit, shift, or day of the week. This made it difficult to determine if facility staff had shown improvement in reducing these occurrences.

Recommendation 4. The Medical Center Director should ensure that IC and risk management data are trended, analyzed, and used to make patient care decisions.

Medical Center Director Comments

A number of improvements in the way data is displayed, analyzed, and reviewed in the IC Committee have been implemented since the OIG's visit. These include use of newly developed, more sophisticated spreadsheets that can easily show tracking and trending of infection data by type and area. This is now accepted as the method by which the IC Committee will review data. Graphs have been similarly updated. Documentation of data review in the committee minutes has also been improved. A recent, routine annual review of the IC Committee conducted by the CEB noted that tracking and trending of infection control data had been enhanced. The facility's practice has been to trend aggregate inpatient falls data over time through use of control charts and other displays. We plan to improve this process by trending similar information by location of the fall, time of day/shift, and day of the week to determine whether there are any outliers that should be addressed.

Office of Inspector General Comments

The Medical Center Director's comments and implementation actions are acceptable. We consider this issue resolved but may follow up on implementation actions.

Management needed to monitor the supervision of medical residents. VHA policy establishes criteria for performing and documenting resident supervision. These criteria include requirements that VHA facilities retain annual attending physicians' evaluations of residents whom they supervise, as well as residents' evaluations of the attending physicians who supervise them. Both VHA criteria and the Accreditation Council for Graduate Medical Education require documentation of the evidence upon which graduated levels of responsibility are assigned to specific residents. Such documentation should be provided for each resident annually. Although some information was maintained on resident post-graduate-year (PGY) levels, VAMC management and staff did not have documentation for individual resident evaluations or graduated levels of responsibility.

General resident-specific information on approved duties, based on PGY level, was maintained in the VISTA system. The affiliated medical school had also developed general lists of approved procedures by PGY level. However, no specific evidence for the approved levels of responsibility for individual residents was available at the VAMC. Instead, it was maintained at the medical school. Further, VAMC staff did not perform annual evaluations of residents so that justifications for the assigned PGY levels could be documented. As a consequence, VAMC management had no means of determining if VISTA information on resident proficiency and responsibilities was current or accurate.

In addition, attending physician performance of supervisory duties was not evaluated by residents as required by VHA policy. Each resident should be allowed to evaluate his/her supervising attending physician's performance as a supervisor and as a teacher. Accordingly, management lacked the benefit of this mechanism to tell them if attending physicians were performing their supervisory and teaching duties acceptably.

The VAMC had no Associate Chief of Staff (ACOS) for Education and no Residency Program Director. The responsibilities normally assigned to these positions were assigned to the Chief, Education Service. We believe that the lack of these key staff resulted in the lack of oversight discussed above. Documenting resident supervision is as critical an element of healthcare delivery as providing that supervision, especially in a heavily affiliated, tertiary care environment. To ensure that VHA policy is met, management should consider appointing an ACOS for Education and tasking the incumbent with responsibility for all aspects of the residency program, including supervision. This would bring the VAMC in line with accepted practice at many other heavily affiliated, tertiary-level VAMCs.

Recommendation 5. The Medical Center Director should ensure that:

- a. All requirements for assigning and documenting PGY levels and graduated levels of responsibility for residents are complied with.
- b. Residents are evaluated annually as required.
- c. Residents are given the opportunity to evaluate supervisory attending physicians.
- d. Consideration is given to establishing an ACOS for Education position responsible for residency programs.

Medical Center Director Comments

All of the above recommendations with regard to the residency program were in effect at the time of the OIG inspection. This facility complies with all requirements for assigning and documenting PGY levels and graduated levels of responsibility for residents. Residents are evaluated annually and are given the opportunity to evaluate supervisory attending physicians. However, in the past, only the University of Louisville School of Medicine maintained those records; they were not also housed here. We have requested copies of these records so they will also be available at the VAMC. Those copies will be on file at this facility no later than October 31, 2001. At this time, we are not actively recruiting an ACOS for Education, as we continue to devote our limited resources to direct patient care positions. This position was abolished several years ago, with Network concurrence, and is not mandated under current provisions of the Academic Affairs manual. The duties of the ACOS for Education have been assumed by two positions. A Ph.D. is responsible for the disbursement agreement for the residency program. This includes meeting with the Associate Dean for Graduate Medical Education regarding administrative issues, making recommendations to the Chief of Staff as to the numbers of resident slots, day-to-day oversight of time and attendance records for the residency program, and ensuring that all paperwork relating to the residency program is processed correctly and on a timely basis. He also coordinates all continuing medical education programs for the facility. The Chief of Staff meets regularly with the residency program director and is the medical center's representative on the University of Louisville Academic Partnership Council. In addition, he meets on a regular basis with the Vice Dean of Clinical Affairs and the Associate Dean for Graduate Medical Education.

Office of Inspector General Comments

We have reviewed the comments furnished by the Medical Center Director and we spoke with him and the Deputy Network Director, VISN 9, in a conference call on September 27, 2001, about issues raised in this report concerning the resident supervision program at VAMC Louisville. We have also reviewed examples of resident supervision forms we received from the Medical Center Director on September 28, 2001. These forms, completed by part-time VA physicians who were also university staff, were not available to us during our onsite review, apparently, because they were housed at the university. However, after examining the forms, we determined that the forms provided did not meet all VHA requirements for form and content. Therefore, we still have concerns about: (a) the lack of a residency supervision program specific to the VAMC, (b) the apparent substituting of the larger university resident supervision program for a VAMC-specific effort, and (c) the lack of a central control point for residency issues, such as an ACOS for Education at the VAMC. Accordingly, OIG and VAMC management will jointly request a site review by staff of the VHA Office of the Chief Academic Affiliations Officer to determine the specific steps to be taken by VAMC management to bring the VAMC into full compliance with VHA requirements for resident supervision.

Timekeeping for and attendance by part-time physicians needed improvement. Part-time physicians in Surgical Service were not always on duty when required. In addition, responsible staff were unaware of VHA timekeeping policies.

VHA policy requires that each part-time physician be present at all times during the “core” hours of his/her schedule. These core hours must make up at least 25 percent of the total hours scheduled during a given pay period. In addition, part-time physicians are responsible for working another set of “adjustable” work hours that complete their tour of duty for a given pay period. These adjustable work hours generally can be worked at any time so long as the physician’s supervisor approves the schedule in advance and the total hours worked equals the total hours for which the physician is paid in a pay period.

We attempted to locate nine physicians during their core hours or at times when they had patient treatment activities scheduled. Three of the nine physicians could not be located. We could not locate two physicians during their adjustable hours at times when they were scheduled to be working in outpatient clinics. VAMC staff were later able to locate one of these physicians at a private hospital. We could not locate a third physician during his core hours at a time when he was also scheduled to be working in a clinic. This physician was also later located at a private hospital.

Surgical Service administrative and timekeeping staff told us that they had difficulty ensuring that physicians worked their required hours. The timekeepers also told us that they were unaware that physicians had to work their adjustable hours in addition to their core hours. They thought that physicians merely had to be available by phone during core hours. In addition, timekeepers did not have personal knowledge of the presence of physicians during the hours listed on their timecards. Rather, they relied on subsidiary timesheets that were completed by the physicians themselves. Therefore, the accuracy of physicians’ claims for hours of work could not be independently verified as intended by VHA policy.

The Director and Chief of Staff stated that in the future part-time physicians would work all hours for which they are paid. They also expressed the hope that recruitment of a Chief of Surgical Service would help alleviate this problem.

Recommendation 6. The Medical Center Director should ensure that:

- a. Part-time physicians work all hours for which they are paid.
- b. Timekeeping staff carry out their responsibilities according to VHA timekeeping requirements.

Medical Center Director Comments

Letters outlining policy relative to core and non-core hours have been developed and will be sent to each physician to clarify their responsibilities and management's expectations regarding their presence for work at the VAMC. The Chief of Staff is responsible for monitoring physician attendance on a biweekly basis and will take appropriate action, as necessary. Timekeeping staff in the involved services have received additional in-service training on timekeeping requirements.

Office of Inspector General Comments

The Medical Center Director's comments and implementation actions are acceptable. We consider these issues resolved but may follow up on implementation actions.

Procedures to resolve accounts receivable needed attention. Since 1993, employee accounts receivable totaling \$302,983 had been canceled, suspended, or written off. Fiscal Service staff took these actions for a variety of reasons, among them was the fact that employees for whom the accounts were established claimed that repayment would have caused financial hardships. A large majority of these accounts receivable were established to collect amounts owed by the employees for educational benefits paid by VBA. Others were established for reasons including leave issues, VA-paid training classes that employees did not complete, unliquidated travel advances, and salary overpayments. Fiscal Service staff took the following actions with respect to these accounts receivable:

- Canceled 81 accounts receivable totaling \$110,959. Fiscal Service staff could not provide us with valid reasons why these accounts were canceled. Furthermore, they said that the history of these accounts could not be audited because of "technical problems with electronic records."
- Suspended 105 accounts receivable valued at \$101,495 after receiving employee waiver requests. Some of these suspensions had been in effect as long as 7 years with no final resolution.
- Wrote off 28 accounts receivable totaling \$90,529 for which there are no documented justifications.

Based on our experience, both the number and value of employee accounts receivable were unusually large. As noted above, documentation on some accounts was unavailable so that they could not be audited. Finally, Fiscal Service staff did not always act on waiver requests timely even when waivers were granted, which is illustrated by the fact that some accounts receivable were pending for as long as 7 years.

Recommendation 7. The Medical Center Director should ensure that:

- a. Processing employee requests for waiver of Federal debts within the 60-day limit provided in VA policy.
- b. All 105 of the suspended accounts receivable are reviewed to determine if waivers are justified.
- c. Collection efforts are carried out on all accounts receivable for which waivers are not found to be justified.
- d. In the future, only accounts receivable that are truly uncollectible are written off.

Medical Center Director Comments

Budgetary constraints at this facility during the current year have resulted in a conscious management decision to focus on recruitment and placement of direct patient care staff. This has had an untoward, although not unexpected, impact upon administrative support services that, nonetheless, endeavor to ensure that their responsibilities are met. It is under these constraints that the facility's Fiscal Service staff process day-to-day transactions and required reconciliations. The Fiscal Service staff reviews outstanding accounts receivable following MP-4, Part 8, and MP-4, Part 1, instructions on waivers and submits the results with my signature to the VBA regional office's (RO's) Waivers and Compromises Committee for action. No waiver request is written off until the VBA RO committee notifies the facility in writing to do so. All other collectible accounts receivable remain in suspense and receive follow-up action as time permits. Fiscal Service has been granted authority to recruit to fill one position; the sole responsibility of the individual selected will be to pursue these accounts receivable. Other vacancies within this section of Fiscal Service will receive first consideration during the position review process early in FY 2002.

Office of Inspector General Comments

The Medical Center Director's comments and implementation actions are acceptable. We consider these issues resolved but may follow up on implementation actions.

The Decision Support System (DSS) was not fully staffed and was not considered reliable. VHA managers are required to implement and use the automated DSS. Congress has expressed its intent that Veterans Equitable Resource Allocation budget requests be based on DSS data. Furthermore, VHA financial managers have stated that DSS will replace other outmoded and less accurate financial reporting systems such as the Cost Distribution Report. Pursuant to this intent, overall program responsibility for DSS was recently transferred to the VHA Chief Financial Officer (CFO). VISN 9 management has expressed support for this

transfer of program responsibility to the CFO, and they also expressed a desire to fully implement DSS within the VISN. As a result of this commitment, other medical facilities in VISN 9 use DSS extensively for decision making.

According to DSS program management in VHA Headquarters, VAMC Louisville was generally in compliance in terms of processing data and entering it into the DSS structure. However, local staff told us that DSS was not used in any way to support VAMC operations. VAMC management further stated that DSS was unreliable and that they did not feel comfortable using it for management purposes. As a reflection of this, the facility had no DSS Clinical Coordinator, and only two FTEE were assigned to DSS maintenance rather than the four FTEE recommended by VHA Headquarters information management staff.

VAMC management should assign 4 FTEE to DSS and consult with the VISN 9 DSS coordinator to obtain assistance in improving the reliability of DSS data so that it can be used in a manner consistent with Congressional intent and accepted VHA practice.

Recommendation 8. The Medical Center Director should ensure that:

- a. Four FTEE are dedicated to DSS.
- b. DSS data is reliable and used to manage VAMC operations.

Medical Center Director Comment

This facility concurs with the conclusion of OIG staff that accurate DSS data is essential to continued facility operations. VISN 9 has submitted a recommendation to VHA to reorganize the DSS function under a VISN product line supervised by a member of the current Network staff, and decisions regarding allocation of additional resources have been deferred pending approval of that proposal. However, the lack of staff does impact the facility's ability to improve data capture; with support of the product line, we can begin recruitment for the two current vacancies and begin to address the issues raised by the OIG. DSS data integrity is an issue that is a national concern, not just a facility concern, and involves standardization of data collection, data validation, training, and other issues. This facility will support the product line manager during the transition to a product line in order to improve data integrity and utilization of the DSS product within VISN 9 and this medical center.

Office of Inspector General Comments

The Medical Center Director's comments and implementation actions are acceptable. We consider these issues resolved but may follow up on implementation actions.

Accuracy of medical record coding for billable episodes of care could be improved. We reviewed compliance with VHA and Medicare policies on the processing of Medical Care Collection Fund (MCCF) billings for third-party payer cases. We interviewed employees and reviewed a sample of 29 billings generated for outpatient visits. We identified the following issues:

- VAMC management did not have policy and procedures for documentation, coding, and billing practices for billable episodes of care. Coding staff were not provided with examples of prohibited or false claims, and they had no descriptions of incorrect coding such as upcoding and downcoding.³
- Although VAMC policy required routine audits of billing procedures, audits were not performed.
- In our survey of 11 clinicians, 1 coding clerk, and 1 Fiscal Service employee, only 9 of these 13 staff knew to whom they should direct questions about coding issues. Only eight had attended coding or billing-related training. While some were aware of VHA and local MCCF billing policies, only six staff correctly identified the individual who was the MCCF Compliance Officer.
- In our review of 29 billed cases for the 2nd quarter of FY 2000, we found 5 instances of upcoding (which resulted in over billings to insurance companies) and 5 instances of downcoding (which resulted in lost revenue to the VAMC).

We discussed our findings with the MCCF Compliance Officer, the Coding Supervisor, and the VAMC Business Manager. All agreed that clinic visits released to the VISN 9 MCCF billing office for third-party insurance company payment should be properly coded. The MCCF Compliance Officer also agreed that improved employee training would be key to implementing an effective coding and billing program.

Recommendation 9. The Medical Center Director should ensure that:

- a. VAMC billing policies are rewritten to include all necessary elements.
- b. Routine audits of billing procedures are performed.
- c. Training is provided to all clinicians and coding employees on medical record coding and billing.

Medical Center Director Comments

A Compliance Officer was appointed in December 2000 to provide guidance and counsel on incorporating compliance-related activities into the operations of this facility. A Compliance Committee was formed to focus predominantly on documentation, coding, and billing issues. Task groups within the committee are developing and planning for implementation of the various aspects of the compliance program. Specifically, they are identifying risk areas, establishing methods for routine monitors/audits, planning and developing compliance training for all employees, and reviewing/rewriting data validation policies. A time line has been developed with realistic expected completion dates. In addition, the following specific training activities

³ Coding is the process of assigning a specific Current Procedural Terminology number to procedures, treatments, and other aspects of care in order to categorize that care. Among other purposes, the code enables billing staff to accurately bill for the specific services rendered. Downcoding occurs when an incorrect code results in a smaller than correct amount being billed to a third-party payer. Upcoding occurs when an incorrect code results in a larger than correct amount being billed to a third-party payer.

have occurred since the OIG visit: compliance training is a segment of new employee orientation and has been offered each month since April; compliance training for supervisors was presented in June; and evaluation and management coding training for all providers, coders, and utilization review staff was presented in July. This training was conducted by experts in the field from outside the VA. Compliance training for managers is scheduled for September. Finally, compliance issues are being reported on a monthly basis at meetings of the Health System Management Council, which direct performance improvement activities for the medical center.

Office of Inspector General Comments

The Medical Center Director's comments and implementation actions are acceptable. We consider these issues resolved but may follow up on implementation actions.

Some Agent Cashier activities needed to be revised. Alternate Agent Cashiers were assigned as Personal Funds of Patients clerks. This meant that when they functioned as Agent Cashiers they had access to both patient accounts and other VAMC cash, causing an inadequate separation of duties.

To replenish Agent Cashier funds, the Agent Cashier made weekly trips to a local bank and returned unescorted to the VAMC with \$3,000 to \$4,000 in currency and coin. Facility police agreed that this presented an unnecessary and unacceptable risk to the employee. VAMC management should arrange to have these funds transported via the regular armored car service used for other Agent Cashier transactions and by Canteen Service.

Recommendation 10. The Medical Center Director should ensure that:

- a. There is appropriate separation of duties for Alternate Agent Cashiers.
- b. Agent Cashier funds are transported via armored car.

Medical Center Director Comments

The facility is attempting to provide for appropriate separation of duties for Alternate Agent Cashiers. This has been complicated by the pending retirement of the primary Agent Cashier and current facility-wide resource issues, as already discussed. We continue to seek means of successfully making this transition within these limitations. At the present time, the only solution that has been identified is to employ an additional full-time employee within the accounting section of Fiscal Service, whose responsibilities would include providing back-up support to the Agent Cashier. This would benefit the facility by having an additional employee to assist with collections as discussed above. The facility is developing a contract at this time with a local armored car service and a local bank that is authorized by the U.S. Treasury to handle funds transactions.

Office of Inspector General Comments

The Medical Center Director's comments and implementation actions are acceptable. We consider these issues resolved but may follow up on implementation actions. However, Agent Cashier duties should be separated from accounting functions at the earliest opportunity.

Background investigations were not conducted on information technology personnel. Security background investigations are required for all staff who have been granted computer access designated as “sensitive,” so that such staff can obtain the necessary security clearances. These investigations need to be updated every 5 years. We reviewed the personnel records of 26 staff whose positions required such clearances. Of these 26 staff, 17 had security clearances that had expired, the oldest having expired in 1985. Therefore, these 17 employees needed updated background investigations so that they could again have current security clearances. Included were the Information Security Officer, eight staff from Information Resources Management Service, and three staff in the Director’s office. Expired clearances should be updated immediately by conducting another background investigation and, once current, background investigations should be repeated every 5 years.

Recommendation 11. The Medical Center Director should ensure that:

- a. Security investigations are conducted for all staff with expired clearances who currently require them.
- b. Security clearances are updated every 5 years.

Medical Center Director Comments

We concur with the recommendations regarding expired security clearances and are currently submitting the required information and Official Personnel Folders to the Office of Security and Law Enforcement for all staff with expired clearances. We expect the review to be complete and appropriate paperwork will be submitted by early September. A process is also being established to assure that the appropriate clearances are updated every 5 years.

Office of Inspector General Comments

The Medical Center Director’s comments and implementation actions are acceptable. We consider these issues resolved but may follow up on implementation actions.

Suggested Additional Actions for Improved Operations

Documentation of primary care provided to mental health patients needed improvement. Reviews of clinical records of 10 mental health patients who each had at least 1 medical condition (i.e., non-mental health condition) showed that all 10 had designated primary care providers and that the providers had assessed and treated each patient’s medical conditions. However, a preventative index had not been assessed and documented in 6 of the 10 records as required by VHA policy. This index measures how well medical care providers follow nationally recognized recommendations for prevention and early detection that, if followed, significantly affect outcomes for specific diseases. These may include screenings for: pneumococcal pneumonia; influenza; tobacco and alcohol consumption; and breast, cervix, colon, and prostate cancer.

The VAMC Director should ensure that the preventative index is appropriately assessed and documented in every patient's clinical record.

Mental health clinicians needed to maintain current treatment plans in patient medical records. A review of medical records for three patients who were treated by attending psychiatrists during the preceding year and who were prescribed controlled substances revealed that two records lacked up-to-date treatment plans. Per VHA policy, up-to-date treatment plans should be available for every patient and, because of the potential for abuse, it is especially important that treatment plans describing the use of controlled substances are available in a patient's medical record.

Psychiatry Service managers were aware of the treatment plan deficiencies and attributed this to the use of CPRS. All pertinent patient information was documented in CPRS except for treatment plans, which were documented in separate paper records. Managers stated that, beginning July 2001, the facility would complete all medical record documentation, including treatment plans, in CPRS.

Informed consents for research involving human subjects needed to be properly documented in all cases. VHA policy requires that the original signed and witnessed patient consent form is included in the medical record of every patient treated as part of a research project. Reviews of medical records for 12 patients showed that an original consent was not included in 1 instance. VAMC management should ensure that original informed consents are included in the medical records of all patients participating in research projects.

Informed consents for surgical procedures were not always adequately documented. Reviews of medical records for 10 surgical cases showed that informed consents were not always documented as required. In one case, the consent form was not witnessed. In another case, the consent form was not annotated with the time that consent was obtained. VAMC management should ensure that all requirements of informed consent for surgery are adhered to.

Pain management policy and documentation of pain-related care warranted review. Reviews of medical records for 10 discharged patients showed that clinical staff documented initial assessments of pain in every case. However, there were other areas that required improved documentation according to VHA policy as follows:

- A pain scale score was not noted in two of seven records as required for patients who had reported pain on admission.
- Five of 10 records showed no evidence that pain was reassessed and recorded each time vital signs were taken as required.
- Six of eight records did not document that pain education had been provided to patients or families as required.

In addition, the VAMC pain management policy did not address the following key elements:

- Employee education for pain management and pain as the "fifth vital sign."

- Timeframes for initial assessment and reassessment of pain.
- Patient and family education regarding pain management.
- Discharge planning for continuing pain management needs.
- Performance improvement monitoring of pain management processes and outcomes.

The VAMC's pain management policy should be updated to include the above items. Also, pain scores should be recorded on admission and followed up each time vital signs are recorded. Finally, education on pain management should be provided to all patients and families for whom it is indicated.

Management and staff needed to continue to address environment of care issues. During tours of inpatient and outpatient care areas, we identified the following as needing corrective actions:

- The Ward 7 South crash cart was in a cluttered room, making access difficult.
- On Ward 5 North, there was a cracked baseboard in a patient shower stall.
- On Ward 6 South, there was hazardous waste in an unlocked biohazard closet.
- On Ward 6 South and in the Medical Intensive Care/Coronary Care Unit, medication room doors were unlocked.
- The Patient Representative's photograph, office location, and telephone number were not posted in patient care areas.

We provided VAMC management with information detailing these five environment of care issues, and managers agreed to take corrective action.

Government purchase card transactions were not always approved timely. We reviewed 2,876 purchase card transactions that occurred between November 1, 2000, and January 31, 2001. We found that 279 transactions had not been approved timely and 15 had not been approved at all. One individual was responsible for 197 of the 279 delinquent approvals.

Management should ensure that all Government purchase card transactions are approved timely. The employee responsible for the 197 delinquent approvals should be counseled, and if the pattern of delinquent approvals persists, his responsibilities for review and approval should be re-assigned to another employee.

Indirect costs for enhanced use sharing agreements were not identified. Review of eight enhanced use sharing agreements revealed six for which staff had not identified all costs incurred by VA such as administrative support to provide the services called for in the contracts. These 6 agreements generated approximately \$2.9 million in revenues for the VAMC. However, this figure should have been offset by indirect costs to the VAMC that should have been calculated in the formulation of the agreements. The Director should ensure that all costs are identified before entering into enhanced use sharing agreements.

Means test documentation needed improvement. We reviewed 30 cases of nonservice-connected treatment that required means test reviews of patients' incomes and assets. In one instance, the test was not documented as required. In another case, someone other than the patient had signed the means test form. In three cases, patient signatures were not dated. The Director should ensure that all means tests are completed properly.

The Report of Survey process needed improvement. Reports of Survey are investigations of missing VA property. Our review of Reports of Survey for the 3-year period immediately preceding our visit identified 2 that were incomplete and pending investigation for 2 and 4 months. Also, the Director had not signed one completed Report of Survey, and a required Uniform Offense Report had not been completed for two reports. Management should ensure that Reports of Survey are done timely and that all elements of the process are completed.

Utilization of a sports and fitness clinic could be improved. A review of workload and interviews with staff revealed that the VAMC's sports and fitness clinic could accommodate more patients than were being referred. The VAMC had recently purchased new exercise equipment for the clinic that significantly expanded the range of activities provided by the clinic's Exercise Physiologist. However, this expanded capacity was not being fully utilized. Management should ensure that patient care staff are aware of the services available for patients in the sports and fitness clinic and implement a Utilization Review monitor for the clinic.

Management should follow up on concerns expressed by employees and patients in surveys. We sent surveys to randomly selected employees, and received other anonymous information from employees. We also interviewed patients.

Forty-five percent of employees responding to our survey said that there was not sufficient staff in their work areas to provide care to all patients for whom they were responsible. Thirty-three percent did not feel comfortable reporting errors that involved other employees, and thirty-eight percent did not feel that constructive actions were taken when errors were reported. Respondents also expressed concerns about the availability of appropriately-sized pajamas for patients and about access to meals or snacks for patients who are admitted after the kitchen is closed. Many of the patients we interviewed expressed concerns about their ability to schedule appointments with their primary care providers within 7 days or to receive prescriptions from the Pharmacy within 30 minutes, as required by VA policy. The full survey results were shared with VAMC management.

VAMC management should resolve the matters described above.

Medical Center Director Comments to Suggestions

I concur with all the suggestions contained herein and will proceed with implementation plans.

Additional Observation

Complaints and allegations about a general lack of cleanliness were not substantiated. We received four hotline complaints that alleged that the general level of cleanliness at the VAMC

was unacceptable and, during our visit, a television station aired a broadcast alleging unsanitary conditions at the VAMC. Complainants also alleged that the VAMC received intensive cleaning prior to external review visits.

Our inspection did not confirm the allegations of unclean conditions. In our judgment, the VAMC was acceptably clean, and appropriate cleaning and general maintenance schedules were established and followed. Also, we found no evidence of any unusual efforts by management to correct or disguise unsanitary conditions because of our impending visit. VAMC managers were aware of, and sensitive to, complaints about the general cleanliness of the facility. Furthermore, they stated that when situations related to cleanliness were identified, they were addressed immediately.

Medical Center Director Comments

The Medical Center Director's initial comments were provided to us in an e-mailed electronic copy of the draft report on August 22, 2001, and e-mails containing revised comments on two issues were also received on September 10 and September 20. The Director's most recent comments to all recommendations are inserted in the appropriate places in the report.

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